State of New Hampshire
Department of Health and Human Services
Division of Community Based Care Services
Bureau of Elderly and Adult Services

SFY 2011 Case Management Program Evaluation

Heritage Case Management

February 2011

Prepared by:

Division of Community Based Care Services
Quality Management

January 2012

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Executive Summary

The Division of Community Based Care Services (DCBCS,) in its commitment to the principles and activities of quality management established a division wide quality management philosophy and infrastructure which included a Quality Leadership Team, facilitated by the Deputy Director, and which is comprised of representatives from the DCBCS bureaus. A number of performance indicators were identified that address either system performance, safety, participant safeguards, participant outcomes and satisfaction, provider capacity, or effectiveness.

One of these performance indicators was to perform annual site visits of the independent case management agencies for the purposes of assuring that the home and community based care elderly and chronically ill waiver program participants' service plans were appropriate, person-centered, that the delivery of services was timely and that the case management agencies had the capacity and capability to deliver or access the services identified in the participants' service plans. This task was subsequently included in the 2007 application for the Home and Community Based Care – Elderly and Chronically Ill waiver as a component of the quality management section of the waiver and is identified as a performance measure for several quality management assurances.

The first annual program evaluation reviews for the five independent case management agencies were completed in May and June of 2009 and were based on the Targeted Case Management Services rule, He-E 805, which was adopted effective August 26, 2008. Program evaluation protocol and a review instrument were developed by a committee that included BEAS staff and which were shared and discussed with the five licensed case management agencies that served participants in the HCBC-ECI waiver program, also known as the Choices for Independence (CFI) program.

The 2009 program evaluation focused on the required case management services of (1) developing a comprehensive assessment, (2) developing a comprehensive care plan and (3) monitoring the services provided to the Elderly and Chronically Ill waiver program participants. A sample of cases was reviewed by a team comprised of staff from the Bureau of Elderly and Adult Services (BEAS) state office, the DCBCS Quality Leadership Team and BEAS Adult Protective Services field staff. The sample size for each agency was determined through the use of a statistical program used by the Bureau of Behavioral Health in its annual eligibility and quality assurance reviews.

Each case management agency received a report that included the results for each of the 38 questions and, when applicable, recommendations for improvement. The agencies were required to submit a quality improvement plan that addressed each recommendation within sixty days of the receipt of its program evaluation report.

BEAS also committed itself to its own quality improvement activity by reviewing the 2009 case management program evaluation process, protocol and review instrument. The results were a reduced number of questions from 38 to 21, the use of a statistical application recommended by the National Quality Enterprise[1] consultants that identified a representative statewide sample for the SFY 2011 program evaluation, and the decision not to rate the timeliness and quality of initial assessments and initial care plans for those cases opened prior to the adoption of the rule, i.e., August 26, 2008, for the SFY 2011 program evaluations.

The protocol and instrument included a four point rating scale, as indicated below:

0	Not applicable, e.g., activity occurred prior to effective date of applicable rule
1	Does not meet minimal expectations, e.g., documentation is missing
2	Meets minimal expectations as established and described in rule
3	Exceeds minimal expectations, i.e., example of best practice

The goal for the initial case management program evaluation was to complete an evaluation on all five of the case management agencies within a few weeks in order to establish a baseline for each agency and for case management for the CFI waiver program as a whole. Going forward, it is anticipated that a complete case management program evaluation will be held annually with each agency that provides case management services to CFI participants. It is anticipated the program evaluation protocols will expand to address additional components of the Targeted Case Management rule, include other pertinent questions and a financial component. These are the goals of the 2010-2011 BEAS Case Management Program Evaluation scheduled bi-monthly from September 2010 through April 2011.

[1] The National Home and Community-Based Services Quality Enterprise (NQE) provides technical assistance on quality to state Medicaid home and community-based services programs (HCBS) and to federal government staff responsible for overseeing these programs.

The NQE is funded by the Centers for Medicare and Medicaid Services (CMS.) under a grant to the Healthcare Business of Thomson Reuters. Professionals from Thomson Reuters and the Human Services Research Institute staff the NQE, along with consultants from other organizations.

Scope and Methodology

A report of participants in the Choices for Independence program as of the end of November 2010 was run which included cases that had been open for at least six months to allow time for a comprehensive assessment, a comprehensive case plan and for services to have been provided for at least a few months. Cases that were closed but had been closed for six months or less as of the end of November 2010 were also included.

A statistical application was used to identify a randomized and representative statewide sample that would yield a 5% confidence interval at the 95% confidence level. A proportionate sample was identified for each case management agency based on the statewide sample. See chart below:

	CFI population (as of the end of Nov. '10)	Statewide representative sample (5% confidence interval; 95% confidence level)	Proportionate sample of Heritage Case Management cases
Heritage	519		69
Total population	2465	332	

The list of cases was distributed to Heritage Case Management approximately three weeks prior to its scheduled state fiscal year 2011case management program evaluation. The program evaluation began with a brief meeting that included introductions, review of the evaluation schedule and an introduction to Heritage Case Management's case record documentation system.

The program evaluation was completed within a week which included an exit meeting where reviewers' observations regarding the cases they reviewed were shared along with informal consultation regarding the agency's documentation system and case practice. The exit meeting included Heritage Case Management's administrative team.

The program evaluation instrument was based on the three sections of the Targeted Case Management rule, i.e., He-E 805, as discussed in the Executive Summary. The program evaluation process, as was emphasized, is a quality management / quality improvement process with the expectation that each agency would produce a quality improvement plan that includes "the remedial action taken and/or planned including the date(s) action was taken or will be taken."[2]

[2] He-M 805.10(b)(4)

Findings and Observations

Preliminary observations were shared with Heritage Case Management at the exit meeting held at the end of the program evaluation.

It was not possible to have gathered and assessed the data from all the case reviews for the exit meeting; the observations shared with the agency staff were a result of the daily and final wrap-up conversations with the program evaluation reviewers.

The ratings for each of the 20[3] questions are presented within the appropriate section of the report. Four questions[4] were rated for timeliness with one rated for both timeliness and quality (question #22) for a grand total of 21 ratings for each of the 69 cases.

Below are two charts that illustrate the rating results with the majority of questions (64%) (932) being rated as meeting minimal expectations (rating of "2"), regarding the items in the He-E 805 Targeted Case Management rule. Five percent (74), of the total questions were rated as not meeting minimal expectations (rating of "1"), e.g., documentation is incomplete. Zero percent (0) of the total questions were rated as exceeding minimal expectations (rating of "3"), e.g. best practice.

total # of "0" ratings	443
total # of "1" ratings	74
total # of "2" ratings	932
total # of "3" ratings	0
Total	1449

% of "0" ratings	31%
% of "1" ratings	5%
% of "2" ratings	64%
% of "3" ratings	0%
Total	100%

[3] The Case Management Program Evaluation instrument was revised with several questions combined for a total of 21 questions for SFY 2011; there were 38 questions in the CY 2009's program evaluations.
[4] Questions #1, 11, 19 and 22.

Two questions addressing timeliness were rated as zero, indicating not applicable, when the items in question were developed prior to the August 2008 adoption of the Targeted Case Management Rule, He-E 805, and thus could not legitimately be rated. Ratings of zero were recorded for the following questions when a Choices for Independence case was opened prior to August 2008:

#	BEAS Case Management Program Evaluation
1	Comprehensive Assessment is conducted within 15 working days of assignment
11	Initial Care Plan is developed within 20 working days of assignment

The majority (41 or 59%) of the 69 cases reviewed were opened prior to the adoption of the He-E 805 rule with 28 (41%) opened after the adoption of the rule.

A zero rating was recorded for questions related to the initial comprehensive assessment (#2-9) for cases opened prior to August 2008. Question #19[5] was rated as zero for cases open less than one year at the time of the review; there were two.

The team leader recorded a zero rating when it was impossible to determine the reviewer's intent when an item was not rated or the rating appeared to be grossly inconsistent with ratings on related questions.

Reviewers were encouraged to include explanatory and helpful comments as they reviewed the cases; a table of their comments, categorized as indicators of "challenges/concerns" and "positive practices" are included in the appendix of this report.

Comparison with CY 2009 Program Evaluation

The June 2009 Heritage Case Management program evaluation results were similar to the February 2011 program evaluation results except for the number of questions, which is explained below, and percent of "0" ratings which, of course, effected the other ratings.

	CY 09	SFY 11
count of 0 ratings	399	443
count of 1 ratings	240	74
count of 2 ratings	2454	932
count of 3 ratings	141	0
totals	3234	1449

[5] Question #19: Care is updated

	CY 09	SFY 11
% of 0 ratings	12%	31%
% of 1 ratings	7%	5%
% of 2 ratings	76%	64%
% of 3 ratings	4%	0%
totals	99%	100%

The CY 09 program evaluation reviewed 66 cases; the SFY 11 program evaluation sample was 69 cases.

The CY 09 program evaluation included 39 questions; the SFY 11 program evaluation included 21 questions by combining related questions and eliminating others that were determined not to be necessary.

The CY 09 program evaluation included 11 questions that were rated for both timeliness and quality (#19, 20, 21, 29, 30, 31, 33, 35, 36, 37, 38); the SFY 11 program evaluation included 1 question that rated both timeliness and quality (# 22).

The change in the SFY 11 program evaluation to not rate the comprehensive assessment questions (#1, 2, 3, 4, 5, 6, 7, 8 and 9) when cases were opened before the approval of the Targeted Case Management rule (He-E 805) resulted in more questions rated as zero and fewer rated as two.

The SFY 11 questions included five that were a combination of two or more questions from the CY 09 program evaluation and seven that were removed. See the appendix for the SFY 2011 program evaluation instrument.

	SFY 2011
1	Same question as CY 09
2	Same
3	Same
4	Same
5	Same
6	Same
7	Same
8	Same
9	Combined with #10
10	See #9
11	Same
12	Removed
13	Same
14	Combined with #15 and #33
15	See #14
16	Combined with #17

	SFY 2011
17	See #16
18	Same
19	Same
20	See #24
21	See #22
22	Combined with #21, 23, 32 and 38
23	See #21
24	Combined with # 20, 27 and 35
25	Same
26	Removed
27	See #24
28	Misnumbering; no #28
29	Same
30	Same
31	Removed
32	See #22
33	See #14
34	Removed
35	See #24
36	Removed
37	Removed
38	See #22
39	Removed

The SFY 2011 program evaluation included a review of the status of each agency's recommendations from its CY 2009 program evaluation and of the agency's policies and practices regarding BEAS state registry regulations.[6]

Recommendations

Based on the ratings and reviewer observations and comments, there are two recommendations made for Heritage Case Management to address in its quality improvement plan.

[6] He-E 805.04(c): Case management agencies shall establish and maintain agency written policies and procedures regarding the following areas, and shall ensure that they are properly followed and enforced: (2) a process for confirming that each employee is not on the BEAS state registry established pursuant to RSA 161-F:49.

Comprehensive Assessment (questions #1-9)

The protocol the reviewers followed was to rate all the questions in this section only if the cases were opened on or after the rule was adopted in late August 2008.

	Questions								
	1	2	3	4	5	6	7	8	9
count of (0) ratings	44	44	44	44	44	44	44	44	44
count of (1) ratings	0	0	0	0	1	0	0	0	7
count of (2) ratings	25	25	25	25	24	25	25	25	18
count of (3) ratings	0	0	0	0	0	0	0	0	0
Total	69	69	69	69	69	69	69	69	69

This section assessed the timeliness of completing the initial comprehensive assessment (question #1) and whether each required section was adequately addressed. The comprehensive assessment is required to address a client's biopsychosocial history (#2), functional ability (#3), living environment (#4), social environment (#5) self-awareness (#6), assessment of risk (#7), legal status (#8) and community participation (#9).

Heritage Case Management's (HCM) comprehensive assessment instrument's content meets the requirement of He-E 805 and the vast majority were complete and well done.

An area need improvement is community participation which is marginally addressed in the Lifestyle section of the *Initial Assessment and Care Plan* form.

When the "0" ratings (44) are eliminated from the total records reviewed (69), for the community participation section question (# 9), seven records were rated as "1", not meeting minimal standards.

HCM is also encouraged to review the reviewer comments that identify some challenges and some positive practices relative to the comprehensive assessment section.

HCM Recommendation #1
Heritage Case Management should provide training, enhance its supervision practices and/or more closely monitor the quality and completeness of its initial comprehensive assessments to ensure that community participation is assessed.

Development of Care Plan (questions #11-19)

		Questions									
		#10 addressed in #9	11	#12 removed	13	14	#15addressed in #14	16	#17 addressed in #16	18	19
count of (0) ratings			44		1	0		0		0	2
count of (1) ratings			0		40	3		12		2	0
count of (2) ratings			25		28	66		57		67	67
count of (3) ratings			0		0	0		0		0	0
Total			69		69	69		69		69	69

This section addressed:

- the timeliness of developing the initial (#11) and annual care plans (#19),
- whether care plans included client-specific measurable objectives and goals with timeframes (#13),
- whether care plans contained all the services and supports needed (#14),
- whether care plans addressed mitigating any risks for abuse, neglect, self-neglect and exploitation (#16), and
- whether care plans included contingency planning (#18).

Reviewers rated questions #13 through #18 based on the most current care plan which would be the initial care plan for cases opened less than a year or the most recent annually updated care plan for cases opened a year or more.

This section of questions proved to be the most challenging for HCM particularly questions #13, and #16.

- Fifty-eight percent (40) of the cases for question #13 were rated as one, does not meet minimal expectations, with forty-one percent (28) of the cases rated as two, meets minimal expectations.
- Seventeen percent (12) of the cases for question #16 were rated as not meeting minimal expectations, with eighty-three percent (57) of the cases rated as meeting minimal expectations.

These results demonstrate a need for HCM to focus on case plan development.

The Reviewer Comments' section includes many comments relative to the cases reviewed and, though there were some care plans that provided evidence of positive practices relative to measurable, client-specific objectives and goals with timeframes (question #13), most care plans were deficient in either one or more of these components.

Reviewers offered a number of suggestions, as recorded in the attached Reviewer Comments' section, of goals from their reading of case records. One opportunity for HCM is to review the *Ready NH* paperwork, specifically items identified as "To Do" items, as the "To Do" items could and probably should be included in care plans as goals to be achieved.

Question #16's results were good though 11 or 16% of the care plans either did not address areas of risk identified in progress notes, e.g., possible exploitation and neglect by a client's relative, or evidence was lacking of the assessment of potential areas of risk. Given how critical risk assessment and management are, HCM should also target this area in its training, supervision and quality monitoring activities.

Question #18's[7] results were much improved from the 2009 Program Evaluation where 42% (28) of case records were rated as one, below expectations; the result for this evaluation was 3% with only 2 records rated as below expectations.

HCM is encouraged to read the Reviewer's Comments' section for examples of both good practice and practice that is in need of improvement. The number of cases in which a comment was pertinent was provided.

Though the current rule does not require that clients be given a copy of their initial and annual case plans, HCM is encouraged to consider adopting this as standard practice rather than to provide copies when requested which is the current practice.

<u>HCM Recommendation #2</u>:
HCM should review its policy and practice regarding developing care plans, provide training, enhance its supervision practices and/or more closely monitor the quality and completeness of its care plans to ensure that all care plans:

1. contain client-specific, measurable objectives and goals with timeframes; and
2. contain services designed to mitigate identified risks for abuse, neglect, self-neglect and exploitation.

Since HCM has not demonstrated improvement from the 2009 Program Evaluation[8] regarding question #13, HCM is expected to enhance its monitoring of clients' care

[7] Question 18: Contingency plan addresses unexpected situations, identifies alternative staffing and special evacuation needs.
[8] Question #13 results were 41% rated as not meeting expectations in 2009 and 58% in 2011.

plans to ensure that they meet the criteria addressed in He-E 805.05(c) through its quality management record review process as described in He-E 805.10.

III. Monitoring and Evaluation of the Care Plan (questions #22-25)

		Questions						
		#20 addressed in #24	#21 addressed in #22	22T	22Q	#23 addressed in #22	24	25
count of (0) ratings				0	0		0	0
count of (1) ratings				0	6		3	0
count of (2) ratings				69	63		66	69
count of (3) ratings				0	0		0	0
Total				69	69		69	69

Reviewers rated contact and progress notes during the period under review, January 2010 – February 2011, but focused primarily on the most current six months, i.e., September 2010 through early February 2011.

This section included three questions, one of which has two parts (#22):

- the timeliness (#22T) and adequacy of contacts with clients, providers and/or family members (#22Q);
- whether services were adequate, appropriate and provided (#24); and
- whether there was evidence that the client was actively engaged in his/her care plan and the case manager was making efforts to engage his/her client (#25).

This section is a strength for HCM as its performance on the three questions was:

- #22T: 100% met expectations (rating of "2")
- #22Q: 91% met expectations
- #24: 96% met expectations, and
- #25: 100% met expectations.

There are no recommendations for HCM regarding the monitoring and evaluation of the care plan section of the program evaluation.

IV. Provider Agency Requirements/Individual Case Record (questions # 29-30)

		Questions	
		29	30
count of (0) ratings		0	0
count of (1) ratings		0	0
count of (2) ratings		69	69
count of (3) ratings		0	0
Total		69	69

This section included the following two questions:

- #29: Face sheet is current and minimally includes client's name, date of birth, address, Medicaid number, emergency contact information including phone number and address; and
- #30: A copy of the current Medical Eligibility Determination (MED) needs list/support plan is in the case record.

The reviewers recognized that obtaining a copy of the current MED from BEAS was not always a timely process so the question was not rated as deficient if the current MED was not in a case record.

This section is also a strength for HCM as its performance is that expectations were met for both questions in this section for all cases.

There are no recommendations for HCM regarding the case record requirement section of the program evaluation.

Quality Management and State Registry

HCM had four recommendations as a result of its CY 2009 Program Evaluation, two of which were suggested recommendations. The two recommendations were:

1. enhance its monitoring of each case manager's care plan development to ensure that:
   a. care plans contain client-specific, measurable objectives with timeframes,

b. care plans address clients' risks for abuse, neglect, self-neglect or exploitation,
c. care plans contain adequate and appropriate contingency planning, and
d. care plans are comprehensively reviewed and updated on, at minimum, an annual basis to assure that the status of all a client's needs, goals and objectives are assessed, addressed and updated as needed.

3. work with the Division of Family Assistance to establish a process that provides clients' Medicaid financial eligibility information including cost shares;

Suggested Recommendations

2. pursue the questions of:
   - how to and the appropriateness of requesting and receiving other providers' care plans, and
   - how to and the appropriateness of including notes from provider meetings in case records.
4. consider documenting their clients' Medicare Part D statuses such as when Part D enrollments are due and whether their clients have the information necessary to make the most appropriate choice of plans.

Regarding recommendation #1, HCM reported that monthly all-staff meetings are held with client record documentation always on the agenda. In addition, the agency's Quality Assurance Team meetings include review of the results of client record audits, and, when completed, the results of Client Satisfaction Surveys, Consumer and Provider telephone surveys.

At HCM's request, BEAS forwarded:

- the risk management materials currently used in the Community Passport / Money Follows the Person program and being developed in the Choices for Independence waiver program, and
- websites that provide software for establishing reliable and valid sample size information useful for quality management activities.

Regarding suggested recommendation #2, HCM discussed the value of receiving other agencies' care plans and case record documentation versus the expense and time to do so and suggested that case managers' contact with their clients and their clients' providers are the more efficient and valuable means of gathering pertinent care planning information.

Suggested recommendation #3 is not a current issue as the department is in the process of enhancing the linkages between two databases, i.e., Options and New Heights to facilitate access to needed information.

HCM reported that case managers do address clients' Medicare questions and their preparedness for Medicare Part D (recommendation #4) and acknowledge that the ServiceLink Resource Centers (SLRCs) provide good assistance and information so clients either self-connect to a ServiceLink or HCM staff may refer them to the appropriate SLRC.

BEAS asked HCM about its policy and procedures regarding submitting the names of new staff to the BEAS State Registry; HCM provided a copy of its *Employee Orientation Checklist*

Conclusions / Next Steps

DCBCS and BEAS appreciate the opportunity to visit the Heritage Case Management agency and to gather information through a review of a number of the agency's case records. DCBCS and BEAS acknowledge that by hosting this program evaluation, HCM spent valuable work time gathering case records, being accessible for questions, and attending the initial and exit meetings with the program evaluation team leader and administrator of the BEAS Community Services and Policy Development unit. HCM staff were very gracious and accommodating.

The 2010/2011 program evaluation is the second designed to review the Targeted Case Management rule, He-E 805, and proved to be another valuable exercise as DCBCS and BEAS continue to work internally and with their stakeholders to improve the quality of the Choices for Independence waiver program and to successfully meet the assurances and subassurances required by the Center for Medicare and Medicaid Services (CMS) of its home and community based care waiver programs for the elderly and chronically ill.[9]

Heritage Case Management is expected to develop a quality improvement plan that includes the remedial action taken and/or planned including the date(s) action was taken or will be taken. The quality improvement plan should be submitted to DCBCS Quality Management at 129 Pleasant Street, Concord NH 03301 within sixty days of the receipt of this report.

[9] See the Appendix for the list of CMS Waiver Assurances and Subassurances

Appendices

Case Management Program Evaluation – Review Instrument

Reviewers' Comments / Observations

CMS (1915c) Waiver Assurances and Subassurances

Abbreviations

Separate Attachment

List of sample cases reviewed and ratings

Case Management Program Evaluation – Review Instrument

Face Sheet

Case Management Agency

Name:
Address:
City/town:

Participant Name

First: Middle initial Last:

Participant (current) Living Arrangement

☐ own home
☐ adult family home
☐ assisted living facility (name of facility):
Check if client resides in one of these facilities: ☐ Meeting House ☐ Whitaker Place ☐ Summercrest
☐ congregate housing
☐ hospital (name of hospital):
☐ nursing facility (name of facility):
☐ residential care facility (name of facility):
☐ other:

Case Information

Participant's Medicaid #:
Participant's date-of-birth:
Participant's (current) Case Manager:
Date of referral to Case Management agency:
Date Case Management case closed:
Reason for case closure:

Program Evaluation Information:

Period under review (from previous annual program evaluation to date of current evaluation): to
Date of Review:
Reviewer First: Last: Agency / Position:

Findings / Ratings (enter # in white (un-filled) boxes)	
1	does not meet minimal expectations, e.g., documentation is missing
2	meets minimal expectations as established in rules
3	exceeds minimal expectations, i.e., example of best practice
0	does not apply

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
805.05(b)		**I.** Comprehensive Assessment (builds on MED, needs list, support plan)			
805.05(b)	1	Comprehensive assessment is conducted within 15 working days of assignment Include date comprehensive assessment completed.	☐		
805.02(b) and 805.05(b)(2)(a)	2	Biopsychosocial history that addresses: • Physical health • Psychological health • Decision-making ability • Social environment (addressed in question #5) • Family relationships • Financial considerations • Employment • Avocational interests, activities, including spiritual • Any other area of significance in the participant's life (substance abuse, behavioral health, development disability, and legal systems)		☐	
805.05(b)(2)(b)	3	Functional ability including ADLs and IADLs		☐	
805.05(b)(2)(c)	4	Living environment including participant's in-home mobility, accessibility, safety		☐	

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
805.05(b)(2)(d)	5	Social environment including social/informal relationships, supports, activities, avocational & spiritual interests		☐	
805.05(b)(2)(e)	6	Self-awareness including whether participant is aware of his/her medical condition(s), treatment(s), medication(s)		☐	
805.05(b)(2)(f)	7	Risk including potential for abuse, neglect or exploitation by self or others; identify whether a separate Risk Assessment has been completed		☐	
805.05(b)(2)(g)	8	Legal status including guardianship, legal system involvement, advance directives such as DPOA		☐	
805.05(b)(2)(h)(i)	9 (and 10)	Community participation including the client's need or expressed desire to access specific resources such as the library, educational programs, restaurants, shopping, medical providers and any other area identified by the client as being important to his/her life.		☐	
805.05(c)		**II.** Development of Care Plan			
805.05(c)	11	Initial Care Plan is developed within 20 working days of assignment	☐		
805.05(c)(1)	12	▪ Removed.			
805.05(c)(2)	13	▪ contains client-specific measurable objectives and goals with timeframes [review most current care plan]		☐	

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
805.05(c)(3)(a),(b)and d (c) and 10-25 GM 5.14.10, and 10-30 GM 7.16.10, and 10-34 GM 7.30.10[10]	14 (and 15 and 33)	▪ contains all the services and supports based on the clients' needs in order to remain in the community and as identified in the comprehensive assessment and MED ▪ paid[11] services (identify) b) non-paid services (identify) c) enrolled in Medicare, Part D, if appropriate *(continued on next page)* d) maximize approved Medicaid state plan services before utilizing waiver services e) identify unfulfilled needs and gaps in services f) if pertinent, has there been consultation with an agency (community mental health center, area agency, etc) regarding diagnosis and treatment [evaluate most current care plan]		☐	
805.05(c)(3)(d) and (e)	16 (and 17)	Risks for abuse, neglect including self-neglect or exploitation and plan for mitigating existing risk(s) Issues identified via sentinel event reporting: • clients smoking while on oxygen • abuse (assaults) • medication abuse [evaluate most current care plan]		☐	

[10] Ensure that homemaker services (HCSP) are not actually personal care (HHCP) and that spouses are not providers
[11] Includes all paid services to be provided under Medicaid, including Medicaid state plan services, or other funding sources.

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
805.05(c)(3)(f), 805.02(l)	18	Contingency plan; the plan that addresses unexpected situations that could jeopardize the client's health or welfare, and which: • identifies alternative staffing • addresses special evacuation needs)		☐	
805.05(c)(4)(a) and, 10-17 GM 4.14.10[12]	19	Care Plan is updated: • annually, and • in conjunction with annual MED redetermination [evaluate most current care plan]		☐	Date of care plan reviewed:
805.05(d)		**III.** Monitoring and Evaluation of Care Plan[13]			
805.05(d)(1)(a) and (b) 2009 CM Program Evaluation Summary Report	22 (and 21, 23, 32 and 38)	No less than one monthly telephone contact and one face-to-face contact every 60 days. *(continue on next page)* Contacts notes with the client, other providers, and/or family members, should be frequent enough to adequately address the client's needs including readiness for annual Medicaid redetermination; location and type of contact (phone, face-face) should be specified. Describe frequency of contacts and with whom.	☐	☐	
805.05(d)(2); and 805.04(f)(7) 10-25 GM 5.14.10[14]	24 (and 20, 27 and 35)	Services are adequate, appropriate, provided as evidenced by: ○ CM agency Care Plan (see ques. #14, 16, 18, 19) ○ CM agency contact notes required for each client ○ Progress notes that reflect areas contained in the care		☐	

[12] Annual redetermination of medical eligibility for the CFI program includes review of the client's needs and process to authorize services
[13] Current terminology: MED process includes development of "service plans" by BEAS Long Term Care Nurse; Case Management agencies develop "care plans"
[14] Per 10-25 GM 5.14.10 (05/14/10): CM must "document types and amount of: home health services, personal care, physical care, physical therapy, occupational therapy, speech therapy, adult medical day, private duty nursing

Rule References He-E 805 [He-E 801 He-E 819]		**Requirement / Topic**	Timeliness	Quality / appropriateness	**Comments** (required for ratings of #1 and #3)
		plan, including authorizations for new or changed services			
805.05(d)(3)	25	Participant is actively engaged in care plan – and case manager is making adequate and appropriate efforts to engage the participant (see contact and progress notes, e-mails and correspondence with clients and providers, notes re case specific meetings with providers)		☐	
805.05(d)(4)	26	Removed			
	28	Instrument misnumbered with #28 overlooked			
805.04		Provider Agency Requirements			
805.04(f) 10-25 GM 5.14.10		**IV. Case management agencies shall maintain an individual case record which includes**:			
805.04(f)(1)	29	Face sheet including current (updated annually with the Care Plan and MED (see #19)) demographic and other information: name, DOB, address, Medicaid #, emergency contact person, phone number, address.		☐	
805.04(f)(2)	n/a	Comprehensive assessment (see 805.05(b))			
805.04(f)(3)	n/a	Care plan (see 805.05(c))			
805.04(f)(4)	30	Current MED needs list/support plan		☐	
805.04(f)(5)	31	Removed			
805.04(f)(6)	34	Removed			
805.04(f)(8)		Contact notes (see 805.05(d)(1))			
Info only	36	Removed.			
Info only	37	Removed			
805.04(f)(10)	39	Removed			

Total questions: 21

General Observations
Include observations pertinent to the case reviewed that have not otherwise been captured by the questionnaire and that would be useful to record as evidence of best practice and/or evidence of challenges to providing effective, appropriate and quality care.

Program Evaluation Completed: Date:
Name:

Quality Management
Program Evaluation Reviewed: Date:
Name:

Original Filed: DCBCS Quality Management
Copy Filed: BEAS Quality Management

BEAS Case Management Program Evaluation: Reviewers Comments / Observations

Heritage Case Management: February 14 – February 17, 2011

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
I. Comprehensive Assessment			
1	Comprehensive assessment is conducted within 15 working days		
2	Biopsychosocial history		
3	Functional ability, including ADLs and IADLs		
4	Living environment		
5	Social environment	• Minimally addressed; answer to question of religious/community affiliation is "no"	• Includes going to church, weekly bingo, reads newspapers and books, watches TV
6	Self-awareness		
7	Risk, including potential for abuse, neglect or exploitation by self or others	• Client has Alzheimer's, is disoriented, has memory deficit, delusions/hallucinations, is anxious and is determined to be high risk re safety, has DPOA for HC and finances. More information about assessing risk should be considered.	• Addressed but only "no" circled to question of "report of abuse" – more of an evaluation would be helpful in light of the fact the client needs total assistance for many ADLs and IADLs including finance
8	Legal status		
9	Community participation	• client moved to res care facility in another community; had attended church regularly in former community but church attendance not addressed in assessment • other than hobby (basketball) noted, nothing else indicated; basketball interest not pursued • only info is that client can access	

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
		community but nothing about client's needs or desires and how to address them • response to question of "religious/community affiliation" is "no" however client lives in family home, is divorced and needs total assistance for many ADLs and IADLS • client moved to res care in new community; only reference is to attending church in former community • assessment states that "yes" client has access to the community but no detail or any needs identified (2) • not addressed (2)	
10	Address in #9		
II. Development of Care Plan			
11	Initial Care plan is developed within 20 working days of assignment		
12	Removed		
13	Care plan contains measurable objectives and goals with timeframes	▪ goals are not client specific or measurable (7 cases) ▪ not client-specific; only goal is to have HCBC services that allow client to stay in the community (24 ▪ reviews) o one client needed eye doctor; could have been short-term	• plan includes more than one long-term goal and a short-term goal; however short-term goal lacks a timeframe • short-term goals identified; includes timeframes (6); e.g.: o client expressed interest

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
		goal o another client needed transportation; could have been short term goal o service gaps & unfilled needs were identified on assessment and should have been included in care plan ▪ goals have no timeframes; no short-term goals/objectives (8 reviews) o example of short-term goal to include on case plan: client's goal of living in own apartment ▪ no short-term goals (3), however: o client overdue for physician appointment and reports being lonely as family is unable to visit o client's health is declining o client wishes to move to another apartment o client needs transportation for appointments ▪ the "to do" items on the Ready NH paperwork could have been short-term goals on the care plan (8) ▪ only goal is "to maintain client safely in the res care" though: o for several months client	in going to the senior center o client needs added supervision; placement in SNF o encourage client to reach out to people, do more activities in new environment (no timeframe or any more detail, however) • plan includes short-term goal to assistance client with bills

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
		indicated she had not seen a doctor, o was lonely but didn't participate in any social activities	
14 (and 15 and 33)	Care plan contains all the services and supports based on the participants' needs in order to remain in the community and as identified in the comprehensive assessment and MED a) Paid services (identify) b) Non-paid services (identify) c) Enrolled in Medicare, Part D, if appropriate d) Maximize approved Medicaid state plan services e) Identify unfulfilled needs and gaps in services f) Consultation re diagnosis and treatment, if pertinent	• Goals are listed but do not reflect gaps/unfilled needs • The identified gap in transportation not included • Goals and services identified in progress notes and from Emergency Preparedness/Ready NH "To Do" items should have been included in Care Plan (4)	• Several non-CFI services included on care plan, (8) e.g.: o Transportation (provided by family) o Mental health services (community provider) o Socialization (provided by residents) • Both paid and unpaid services are identified
15	Addressed in #14		
16 (and 17)	Risks for abuse, neglect including self-neglect or exploitation and plan for mitigating existing risk(s)	• no mention of risk of exploitation/abuse which is a concern due to client's dementia • not well addressed, assessed; states "to the best of his mental ability" • risks are identified but there is no plan to mitigate them (5) • risk of neglect: live-in PCSP works and client does not get lunch or daily exercise despite having homemaker services • no info re how to mitigate	• risk factors identified include: impaired mobility, depression, dementia • is also assessed monthly

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
		identified "risk of injury" (2) • no evidence of being assessed (3) • progress notes indicate client's behavior puts him at risk of abuse and harm to himself ▪ a possible exploitation situation was identified and recorded in progress notes but not reflected on the care plan ▪ progress notes indicate exploitation and possible neglect by client's niece but not addressed in care plan	
17	Addressed in #16		
18	Contingency plan addresses unexpected situations, identifies alternative staffing and special evacuation needs	▪ lacking backup plan if assisted living facility evacuated ▪ plan is that client would be safe for 1 or 2 days however client cannot exit home w/out assistance as he is over 400 lbs ▪ limited to "find another res care"	▪ a "great" Emergency Evacuation Agreement" completed which was reviewed with the client ▪ great job completing the Ready NH paperwork (6 reviews) ▪ Ready NH paperwork completed; includes things "to do" including a meeting place outside the home and a "go kit" (7)
19	Care plan is updated: annually, and in conjunction w/annual MED		
20	Addressed in #24		
21	Addressed in #22		

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
III. Monitoring and Evaluation of Care Plan			
22 (and 21, 23, 32 and 38)	No less than 1 monthly telephone contact and 1 face-to-face contact every 60 days	• Monthly notes only say that client loves living at res care facility. CM only speaks to client; no indication that CM spoke with staff about client (2) • Monthly notes are exactly the same for at least 6 months • No evidence of CM contact with facility staff or client's daughter, who is DPOA, about client's status; no evidence of follow-up on client's overdue physician appointment • Although there were monthly contact notes; there was no substance to them; there was no evidence to support the need and benefit of the case management in res care (2) • Difficult to determine when (and if) contacts were face-to-face (2)	• CM balanced speaking with both the client and res care staff (2) • Visited client each month (res care); talked with staff each time • Monthly visits with client; CM usually speaks with staff and speaks with family member when needed (2) • Reviewer comment: "needs are met by res care staff and her daughter who is active in her life" • Notes are comprehensive; CM stays in contact w/client, wife and sister who is PCSP • Notes are comprehensive; follows client's care during hospitals stays • CM informed client and physician's office of CM's upcoming vacation & person to contact in her absence • Notes are comprehensive • Many contacts per month; often face-to-face
23	Addressed in #22		
24 (and 20,	Services are adequate, appropriate, provided as evidenced by:	• Progress notes are the same for at least 6 months with no info	• CM visits client at day program; no evidence of speaking with

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
27 and 35)	• CM agency Care Plan • CM agency contact notes • Progress notes	regarding quality and appropriateness of services • Client also has mental health case manager; both case managers worked on transitioning client from res care to an apartment. Good cooperation but possible example of duplication of case management services • nothing in care plan re client's failing eyesight and furniture-walking as risks for falling ▪ client has history of not paying rent and of self-neglecting; possibility of being homeless not addressed	staff • Lot of effort to transfer client from res care to living in an apartment with everything clients needs • Progress notes are comprehensive and concise; can tell what's going on • Record reflects increases and decreases in services to match the client's needs
25	Participant is actively engaged in Care Plan		○ CM always engages w/client when visiting or calling even tho client not always responsive ○ Well documented (2) ○ CM regularly asks client if she has any concerns or needs anything
26	Removed		
27	Addressed in #24		
28	Error in numbering		
IV. Provider Agency Requirements / Individual Case Records			
29	Face sheet		
30	Current MED needs list / support plan		

Question		Reviewer Comments	
		Challenges/Concerns	**Positive practices**
31	Removed		
32	Addressed in question #22		
33	Addressed in question #14		
34	Removed		
35	Addressed in question #24		
36	Removed		
37	Removed		
38	Removed		
39	Removed		

General Observations	
Challenges / Concerns	**Positive practices**
"To Do" items identified on Ready NH/Emergency Preparedness Planning Form should be included on care plans	Emergency preparedness planning form used is very comprehensive; "To Do" items could be included in case plan as goals/objectives.
Progress notes reflect short-term goals that could have been included on care plans: o Research ICF placement o Need for food stamps o Need for walker	Agency develops new *Monthly Assessment and Care Plan* every month which includes, other non-HCBC services, list of authorized waiver services attached, goals and objectives section includes long-term and short-term goals
Some clients were identified as "at risk for injury" but plans to address the risk were not developed. The risk for abuse, neglect was often not addressed	Evidence of CM being a strong advocate for the client.
Contingency Plan includes space to record "client risk factors" but does not specify potential risk of abuse, neglect	Chart is well documented; there is evidence of good interaction with providers.
Some progress notes are not comprehensive; have minimal content.	Progress Notes well done.
97 year old in assisted living facility is visited by case manager but no evidence of case manager being in contact with facility, family or daughter who is DPOA	Many cases have Ready NH forms completed for emergency preparedness but "to do" items are not reflected in the contingency plan or care plan – both a challenge and positive practice
Reviewer noted that one case manager's clients' care plans all had the same goals	Risk of abuse or neglect not addressed but other risks identified: smoke, isolation, impaired mobility – both a challenge and positive practice
Question of duplication of effort between LTC case manager and CMHC case manager.	Record was well documented. The notes and care plan allowed one to see what the client's needs were and what services were needed.
Risk of abuse or neglect not addressed but other risks identified: smoke, isolation, impaired mobility – both a challenge and positive practice	

General Observations	
Challenges / Concerns	**Positive practices**
Many cases have Ready NH forms completed for emergency preparedness but "to do" items are not reflected in the contingency plan or care plan – both a challenge and positive practice, e.g. • Contingency plan is "to call family" • Ready NH form "to do" include: o Extra key for emergencies o Advance care directives o Non-electric telephone o "go kit"\ o evacuation plan	
Information in progress notes not reflected in care plan	

CMS (1915c) Waiver Assurances and Subassurances		
Assurances	**Subassurances**	
Level of Care	Persons enrolled in the waiver have needs consistent with an institutional level of care	
	Subassurances	a. An evaluation for Level of Care (LOC) is provided to all applicants for whom there is reasonable indication that services may be needed in the future
		b. The levels of care of enrolled participants are re-evaluated at least annually or as specified in the approved waiver
		c. The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care
Service Plan	Participants have a service plan that is appropriate to their needs and that they receive the services/supports specified in the plan	
	Subassurances	a. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means
		b. The state monitors service plan development in accordance with its policies and procedures
		c. Service plans are updated / revised at least annually or when warranted by changes in the waiver participant's needs.
		d. Services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency specified in the service plan
		e. Participants are afforded choice: e.1. between waiver services and institutional care e.2. between / among waiver services, and e.3. providers

CMS (1915c) Waiver Assurances and Subassurances		
Assurances	**Subassurances**	
Qualified Providers	Waiver providers are qualified to deliver services / supports	
	Subassurances	a. The state verifies that providers, initially and continually, meet required licensure and / or certification standards and adhere to other standards prior to their furnishing waiver services
		b. The state monitors non-licensed / non-certified providers to assure adherence to waiver requirements
		c. The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.
Health and Welfare	Participants' health and welfare are safeguarded and monitored	
	Subassurance	The state, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.
Financial Accountability	Claims for waiver services are paid according to state payment methodologies	
	Subassurance	State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.
Administrative Authority	The State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for all facets of the program.	
	Subassurance	The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local / regional non-state agencies (if appropriate) and contracted entities.

Abbreviations

Abbreviation	Terminology
ADL	Activities of Daily Living
BEAS	Bureau of Elderly and Adult Services
CFI	Choices for independence program, formerly known as the Home and Community Based Care Services – Elderly and chronically Ill Waiver Program (HCBC-ECI)
CM	Case Management or Case Manager
CMS	Center for Medicare and Medicaid Services
CY	Calendar Year
DCBCS	Division of Community Based Care Services
DPOA	Durable Power of Attorney
HCBC – ECI	Home and Community Based Care Services – Elderly and Chronically Ill Waiver Program renamed the Choices for Independence program (CFI)
HCM	Heritage Case Management
IADL	Instrumental Activities of Daily Living
LOC	Level of Care
NF	Nursing Facility
PCP	Primary Care Physician
PCA	Personal Care Attendant
PCSP	Personal Care Service Provider
PES	Participant Experience Survey
POC	Plan of Care
SFY	State Fiscal Year